Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DOCTORS HOSPITAL OF LAREDO
3255 W PIONEER PKWY
ARLINGTON TX 76013

Respondent Name
LM Insurance Corp

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-11-4974-01

MFDR Date Received
August 29, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have found in this audit they have not paid what we determine as a "fair and reasonable" amount for the ER line item charge."

Amount in Dispute: $55.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Authorization was requested for code 97032 but was denied. Charges were processed accordingly."

Response Submitted by: Liberty Mutual, 2875 Browns Bridge Road, Gainesville, GA 30504

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
May 16 -18, 2011	Outpatient Hospital Services	$55.20	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective review of health care.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - X388 – PRE-AUTHORIZATION WAS REQUESTED BUT DENIED FOR THIS SERVICE PER DWC RULE 134.600

Issues

1. Did the respondent support the insurance carrier's reason for denying procedure code 97032?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?

Findings

1. The insurance carrier denied disputed services billed under procedure code 97032 with reason code X388 – PRE-AUTHORIZATION WAS REQUESTED BUT DENIED FOR THIS SERVICE PER DWC RULE 134.600." Per 28 Texas Administrative Code §134.600(c)(1), effective May 2, 2006, 31 *Texas Register* 3566, the carrier is liable for all reasonable and necessary medical costs relating to the health care listed in subsection (p) only in the case of an emergency or "preauthorization of any health care listed in subsection (p) . . . that was approved prior to providing the health care." §134.600(p)(2) states that the non-emergency health care requiring preauthorization includes " physical and occupational therapy services." No documentation was found to support that the services in dispute had been preauthorized. The insurance carrier's denial reason is supported.
2. In its request to medical fee dispute resolution, the requestor states that "We have found in this audit they have not paid what we determine as a "fair and reasonable" amount for the ER line item charge." Review of submitted documentation found no reduction or denial other than that for no prior authorization nor where the disputed charges related to an ER visit. Therefore this service was reviewed per applicable rules and fee guidelines set out in 28 Texas Administrative Code §133.307.
3. The total recommended payment for the services in dispute is $0.00. The requestor is seeking $55.20. This amount is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October , 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.